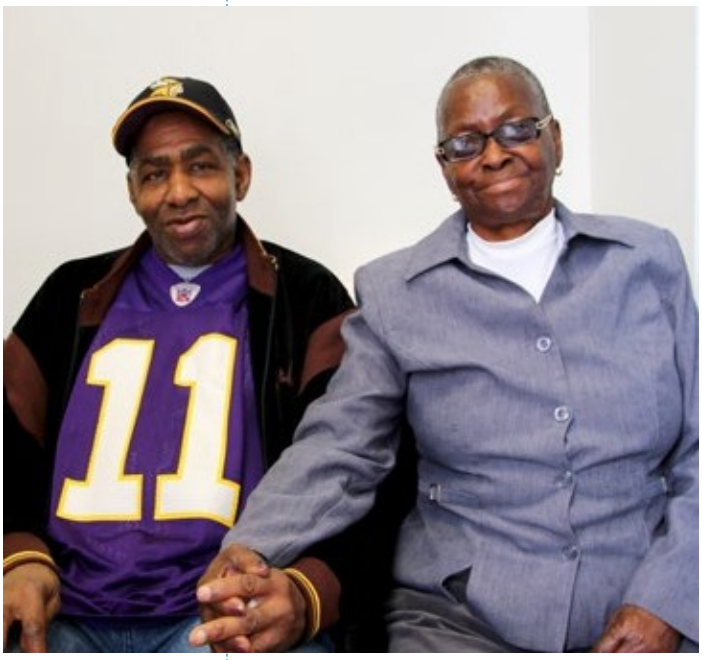
Health Home Links Patients with Complex Issues to Needed Services



Harlem Hospital patients Samuel Graves and Mary Marks say participating in the Health Home program has helped them take control of their health conditions.

For years, it was not easy for Mary Marks, a patient with both medical and behavioral health issues, to manage her conditions and stay out of the hospital. But taking part in the Health Home program at Harlem Hospital Center has changed that. "I haven't been hospitalized in years," says Marks, "and that makes me feel good."

The Health Home program is a new initiative for patients who frequently use Medicaid services and have significant medical or mental health issues. Health Home patients work with a Care Coordinator to manage medical, behavioral, and social needs. With personalized knowledge of their clinical conditions and other needs, the Care Coordinator creates a customized care plan for each program participant.

Whether it is linking patients to a primary care provider, arranging for specialty services, or referring them to substance abuse treatment, the connections that Care Coordinators make help their clients avoid frequent trips to the emergency department and prevent unnecessary hospitalizations. "I help my clients understand the connection between their medical and behavioral health," says Myrtle Brown, a Care Coordinator at Bellevue Hospital Center. "When patients stay on top of both their physical and mental health conditions, they are much less likely to end up in a hospital."

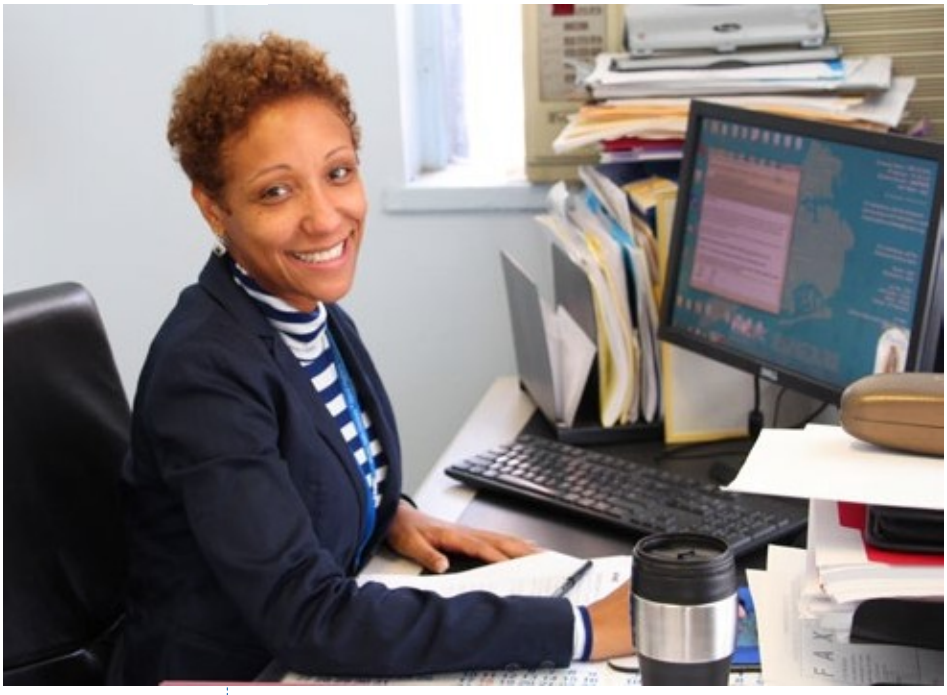
More than 1,500 HHC patients are currently enrolled in the program. Although the Health Home concept is new, the practice of care coordination is not – HHC facilities have provided such support to patients for years. But Julie Watt, Health Home Supervisor at

Harlem Hospital, says this approach creates more opportunities for Care Coordinators to engage with their clients.

"If my client has a doctor's appointment, I can sit in on that visit and meet with the provider," says Watt. "Together, we review the client's needs and discuss what I can do to help the client minimize high-risk behaviors or activities," she says.

Care Coordinators ensure that clients follow their medical plan of care, such as taking medications or improving their eating habits.

"A client with behavioral issues may have a difficult time following up medically, and I can help them stay on track through patient education and connections to other resources," says Watt.



Julie Watt, Health Home Supervisor at Harlem Hospital.

Health Home participants are often linked to health services within HHC, making it easier for Care Coordinators to stay in touch with providers and check up on the progress of their clients. "Referring clients to care within HHC gives us a huge 'home field' advantage," says Watt.

Care Coordination with a Side of Culture

"I was really lost without Myrtle," says patient Felicia Hadley (left), pictured with Care Coordinator Myrtle Brown.

Oftentimes, Care Coordinators connect clients to more than just health services. Many Health Home participants face other challenges – such as housing, employment, or legal issues – that affect their ability to safeguard their health.

For example, Felicia Hadley receives her medical and psychiatric care at Bellevue, but is also working on her literacy skills, thanks to Care Coordinator Myrtle Brown. "Learning how to read and write is very important to me. Myrtle helped me find the classes I need," says Hadley. "I was really lost without Myrtle."

Brown also does what she can to expand client exposure to arts and culture. She often arranges trips to the movies or museums for her clients, giving them an opportunity to socialize with each other. "Many clients haven't been to the movies or a museum in years," says Brown. "Going to a public place like that can be a difficult experience for someone with behavioral health issues."

Recently, Watt called the primary care provider for Marks to discuss a particular health issue. The provider later followed up with Marks directly, phoning her to discuss the issue and evaluate how she was doing. “That was the first time a doctor has ever called her at home,” says Watt. “She was very appreciative of that connection.”

Such outings inspired many clients to create their own works of art that are now displayed in a client resource room near Brown’s office. “Many clients tell me they have a new appreciation for art, and their work shows it,” says Brown.

Artwork by Bellevue’s Health Home Program Participants: